DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

BUMEDINST 6600.12A
BUMED M3
17 Jul 2008

BUMED INSTRUCTION 6600.12A

From: Chief, Bureau of Medicine and Surgery

Subj: NAVMED 6600/3, DENTAL HEALTH QUESTIONNAIRE

Ref: (a) MANMED Chapter 6

Encl: (1) Sample Completion of NAVMED 6600/3

1. Purpose. To issue guidance for use of the Dental Health Questionnaire, NAVMED 6600/3.

2. Cancellation. BUMEDINST 6600.12.

3. Scope. This instruction applies to dental health care providers in all naval Medical Treatment Facilities (MTFs) and Dental Treatment Facilities (DTFs) ashore and afloat.

4. Background. The health and physical status of dental patients must be determined before rendering any dental care to protect the well-being of all dental patients, as well as staff personnel. The documentation of health and physical status is an important element of the medical-legal record of dental care.

5. Policy and Procedures

a. All providers of dental treatment in naval MTFs and DTFs must ensure that each patient presenting for dental treatment has a completed, current Dental Health Questionnaire (NAVMED 6600/3) in the dental record before providing any treatment, including examinations.

b. Steps to complete NAVMED 6600/3. Enclosure (1) is an example.

(1) Each patient presenting for dental treatment must complete the questionnaire and sign and date where indicated at least annually or whenever significant changes in medical status occur. For minors, i.e., under the age of consent or majority in the applicable jurisdiction, the parent or guardian must fill out the form and sign in the patient's signature block of the questionnaire, using his or her name and not the child's name.

(2) A licensed independent practitioner privileged in the practice of dentistry (hereinafter referred to as "dental officer") must review the questionnaire with the patient, and sign and date where indicated.

updated per the guidelines delineated in (1) and (2) above, using the following annotations: "HQR dtd (date) (findings)." The findings can be "within normal limits (WNL)," or can be significant items which affect the treatment provided. It is not essential to restate all positive responses on the NAVMED 6600/3 unless pertinent to the treatment at hand.

c. NAVMED 6600/3 allows for the completion and update of the form/questionnaire by both patient and dental officer four times on the same sheet. Re-use of the questionnaire in this manner is authorized if no significant interval changes have occurred in the patient's medical status.

d. Whenever a significant change in medical history or health status occurs, a new questionnaire must be filled out, dated, and signed by the patient and reviewed by a dental officer.

e. The initial and all later Dental Health Questionnaires must be permanently maintained in the dental treatment record per reference (a).

f. For patient situations which require clarification or consultation from the patient's medical provider, use of applicable local command channels for seeking medical consultation is required. Documentation of the consultation in the appropriate space in the dental treatment record and in the summary of pertinent findings section of the NAVMED 6600/3 is required.

6. Forms. NAVMED 6600/3 can be downloaded from the BUMED website.

T. R. CULLISON
Acting

Distribution is electronic only via the Navy Medicine Web site at:
http://navymedicine.med.navy.mil/default.cfm?selTab=Directives

Sample Completion of NAVMED 6660/3

DENTAL HEALTH QUESTIONNAIRE | Personal Data - Privacy Act of 1974 | **BUMEDINST 6600.12**

My chief complaint or Reason for this Examination is: ANNUAL EXAM NO COMPLAINTS

HAVE YOU EVER HAD OR HAVE YOU NOW: *(Please check at the Right of each item)*

(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW
Epilepsy or Seizures		✓		Hemophilia		✓		Ulcers		✓	
Fainting or Dizziness		✓		Bruise or Bleed easily		✓		Kidney problems		✓	
Nervousness		✓		Heart problems or Angina		✓		Venereal disease		✓	
Stroke		✓		Hypertension		✓		Diabetes		✓	
Glaucoma		✓		Rheumatic fever		✓		Thyroid disease		✓	
Cold sores (Herpes)		✓		Heart murmur		✓		HIV +		✓	
Persistent cough		✓		Mitral valve prolapse		✓		Arthritis		✓	
Emphysema		✓		Congenital heart lesions		✓		Painful joints (incl. jaw)		✓	
Tuberculosis/PPD positive	✓			Heart surgery		✓		Prosthetic joint(s)		✓	
Asthma		✓		Prosthetic heart valve(s)		✓		Hives		✓	
Hay fever		✓		Pacemaker		✓		Steroid medication(s)		✓	
Sinus problems		✓		Blood transfusion(s)		✓		Drug addiction		✓	
Anemia		✓		Liver disease		✓		Alcoholism		✓	
Sickle cell disease		✓		Yellow jaundice		✓		Unexplained weight change		✓	
G-6PD deficiency		✓		Hepatitis - type:		✓		Cancer/radiation		✓	

1. Have you ever been told that you should not donate blood?
2. Have you ever been told that you need antibiotics before dental treatment?
3. Females: Are you taking birth control pills (BCPs)?
   Are you or might you be pregnant? (Estimated delivery)
   Are you breast feeding at the present time?
4. Do you have a disease, condition, or problem not listed above? ✓
   If yes, Please Describe:

INSTRUCTIONS: Please answer the following questions by circling, and if applicable by entering the appropriate response: If yes, describe - If no, please write "no/none"

1. **Are You In: Flight Status .. Yes (YES) / Personnel Reliability Program?**
2. **Are You Presently Ill Or Under The Care Of A Physician** **YES (NO)**
   If Yes, Please Describe:
   History Of Hospitalizations:
   (Including Cancer Treatment)
3. **Any Allergies?** (Including Rubber)
4. **Medications Presently Taking:** NONE
   (including aspirin, etc.) NONE

Any Family History Of: (Circle)
Heart Disease Cancer
Diabetes Seizures

Your Social History:
●Type and frequency of:
●Tobacco use: (age started?)
●Alcohol consumption:

Occupation/Jobs: IT-3
Don't Smoke
1-3 Beers on weekend

Patient's Signature	Date	Dental Officer's Signature	Date
John Q Doe	14 Jul 2008	G. V. Black	14 Jul 2008

SUMMARY OF PERTINENT FINDINGS/RECOMMENDED TREATMENT MODIFICATIONS: *(Dentist's use only)*

Pt noted to be PPD+ at boot camp; no hx TB; received full prophylactic course of Anti-tuberculous medications; no contraindications to dental tx; see SF513.

PATIENT'S IDENTIFICATION *(Use Space for Mechanical Imprint)*

Patient's Name (Last, First, Middle Initial)			SEX
DOE, JOHN Q.			M
DATE OF BIRTH	**RELATIONSHIP TO SPONSOR**	**COMPONENT/STATUS**	**DEPART/SERVICE**
13 Sep 86			
SPONSOR'S NAME			**Rank/Grade**
			IT-3
SSN OR IDENTIFICATION NO.		**ORGANIZATION**	
123-12-1234		U. S. NAVY	

NAVMED 6600/3 (Rev. 1-92)
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